No. 1-13-0709

IN THE APPELLATE COURT OF ILLINOIS
FIRST JUDICIAL DISTRICT

In the Matter of **TORRY G.**, Alleged to be a person subject to involuntary medication Respondent-Appellant	Appeal from the Circuit Court of Cook County No. 2013 CoMH 142 Honorable David Skryd, Presiding Judge

BRIEF OF RESPONDENT-APPELLANT

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Oral Argument Requested

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NATURE OF THE CASE

The trial court ordered Torry G., age 21 (S.18)[1], to be administered involuntary psychotropic medication although it found that Torry acknowledged his mental illness, and that, "[i]n his own testimony, he said he'd be willing to take certain medications." (S.125) The trial court entered an order for the involuntary administration of Tegretol, Zyprexa, Depakote, Fluphenazine HCL (short-acting), Fluphenazine Decanoate (long-acting), Invega, Invega Sustenna (long-acting), Haldol, and Haldol Decanoate (long-acting), on March 7, 2013, and denied Torry's motion for stay pending appeal. (C.28-29,85) Torry raises no questions on the pleadings.

JURISDICTIONAL STATEMENT

Jurisdiction of the Appellate Court is invoked pursuant to Supreme Court Rule 301, this case being an appeal from the Circuit Court's final judgment entered on March 7, 2013. (C.28-29)

ISSUES PRESENTED FOR REVIEW

I. Whether the State failed to prove that Torry G. met each element of the involuntary-medication statute, Section 2-107.1 of the Mental Health Code.

  A. Whether the evidence weighs in favor of finding that Torry has capacity to make a reasoned decision for himself about psychotropic medication.

  B. Whether Torry's willingness to accept voluntary medication is less restrictive than the court ordering involuntary medication.

II. Whether this appeal falls within recognized exceptions to the mootness doctrine.

STATUTE INVOLVED

405 ILCS 5/2-107.1 Administration of psychotropic medication and electro-convulsive therapy upon application to a court. (2012)
(in pertinent part)
(a-5) Notwithstanding the provisions of Section 2-107 of this Code, psychotropic medication and electroconvulsive therapy may be administered to an adult recipient of services without the informed consent of the recipient under the following standards:

> (4) Psychotropic medication and electroconvulsive therapy may be administered to the recipient if and only if it has been determined by clear and convincing evidence that all of the following factors are present. In determining whether a person meets the criteria specified in the following paragraphs (A) through (G), the court may consider evidence of the person's history of serious violence, repeated past pattern of specific behavior, actions related to the person's illness, or past outcomes of various treatment options.
>
> > (E) That the recipient lacks the capacity to make a reasoned decision about the treatment.
> >
> > (F) That other less restrictive services have been explored and found inappropriate.

STATEMENT OF FACTS

Torry G., age 21 (S.18), had been a good student in high school. (S.113A[2]) "I got A[']s when I tried. You know, when I gave my 100 percent, I got A[']s. Whatever I put in, I got out." (S.116A) But Torry did not graduate and now hoped to pursue his GED (General Education Development) high-school equivalency certificate. (S.116-117) Torry had used marijuana as a teenager, and at age 17 had been brought to a hospital for using marijuana that was laced with PCP (Phencyclidine), a hallucinogen/dissociative anesthetic that can cause short- and long-term effects on the

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[1] The record is referred to in this brief in the following way: C.__ = common law record; S.__ = supplemental record containing the report of proceedings.

brain that can simulate symptoms of mental illness. *See generally* Phencyclidine fact sheet (accessed at http://www.nhtsa.gov/People/injury/research/job185drugs/phencyclidine.htm); *see also* National Research Council and assorted panels, *Possible Long-Term Health Effects Of Short-Term Exposure To Chemical Agents* 67 (1984). (S.109-110) When Torry was brought to the hospital related to the PCP-laced marijuana, "[t]hey took me on the psych ward to evaluate me at 17; and when I was evaluated at 17[,] that began my [first] hospitalization." (S.110) Before that, Torry had never been in a hospital overnight. (S.110)

Torry was prescribed psychotropic medication at the time. (S.109) Because he was a minor, "I did not have the right to decline the medicine." (S.109) "[S]o I was experiencing these side effects and I didn't have the right to say [']no, I don't want to take these medicines.[']" (S.109)

Torry explained that he had to go to the emergency room twice since age 17 because of psychotropic medications he was taking: once because "I fell over while I was at outpatient treatment for substance abuse and mental illness," and another time because of severe Lithium[3] headaches. (S.106-107) "I had to go to the emergency room then [because of the severe Lithium headaches], and they gave me morphine and

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[2] This page in the record does not have an appellate page number. Because it is the page after page no. 116 in the Supplemental Record, counsel is referring to the page here as 116A. (The number 113 is printed at the bottom middle of this page.)

[3] Lithium is a psychotropic medication of the anti-manic type, or mood stabilizer, used for treating Bipolar Disorder. http://www.nlm.nih.gov/medlineplus/druginfo/meds/a681039.html.

stuck a needle in my back and took spin[al] fluid out to do a test on me for some reason." (S.107)

Torry experienced other side effects from psychotropic medication prescribed in the past four years. He had muscle spasms under psychiatrist Dr. Richard Goldberg's care during a past hospitalization. (S.107) He was taking four or more medications at that time, including the mood stabilizer Depakote and the antipsychotic Risperdal, and did not know which had caused the muscle spasms. (S.107-109) He explained he also experienced restlessness, difficulty sleeping, and bizarre behavior while on psychotropic medication but that these side effects had worn off and his behavior improved when Dr. Goldberg discontinued the medication. (S.108-109) He also discussed the side effects he had experienced with the hospital counselor who led group therapy sessions during his admission at the time of the present case. (S.98)

Torry also suffered side effects of psychotropic medication during his current admission that began January 1, 2013. (S.16) Torry received two doses of Thorazine as a "PRN" (or, as needed, see def'n at Dictionary.com. *Dictionary.com Unabridged*. Random House, Inc. http://dictionary.reference.com/browse/prn). (S.48,63) Dr. Goldberg discontinued the Thorazine on February 10, 2013, because Torry experienced orthostatic hypotension after receiving the medication. (S.63) The trial court did not let Torry's counsel question either Dr. Goldberg or Torry about the first dose of Thorazine Torry received (on January 22, 2013, S.68) or about the side effect he experienced at that time. (S.70,116A - see footnote 2 above)

Dr. Goldberg diagnosed Torry with bipolar disorder, manic phase, with psychosis, and with past cannabis use or substance abuse. (S.27,58) Dr. Goldberg

testified that Torry had alleged grandiose delusions: Torry "insisted that this trial was going to be about me [Dr. Goldberg], and once the judge heard his testimony about me, that I would go to prison," and that the doctor was "guilty of crimes against patients and so forth." (S.27) Torry testified that he got along poorly with Dr. Goldberg because "he's an arrogant doctor in my honest viewpoint." (S.115)

Torry acknowledged his illness and wished to get reliable treatment for it.

> Well, I can't say that I have full-blown bipolar, but I do realize that I had symptoms of bipolar which I believe some of the symptoms were from certain medicines I received; and I also believed I had some schizoaffective, you know, symptoms as well as depression symptoms along, you know, with other symptoms that I deserve and I believe that those problems needed to be addressed because I didn't like what state I was in, but now my state is getting better.

(S.111) Torry explained that he would like to find a "reliable medication" to treat his illness. (S.117; S.98) He explained that he was not concerned about minor side effects like weight gain or constipation, but was concerned with the more "deadly" side effects that could occur. (S.112)

Torry was aware that some of the proposed medications could cause suicidal thinking. (S.112) Dr. Goldberg acknowledged that some young people can have suicidal thinking on the proposed medications, but said he did not want Torry to experience this effect from the treatment. (S.49-50) Dr. Goldberg testified that Torry had told him about his concerns:

> He [Torry] at times thinks [it] will poison him and he will be seriously harmed. He's been wanting to kill himself because I was giving him medicine, at least it was reported or indicated some suicidal thinking in

> young people. I sure don't want him to commit suicide.
> He accused me of that.

(S.49-50)

Torry also explained other ways he deals with his illness. He participates in individual therapy sessions with his assigned hospital social worker. (S.111) Most recently he had discussed concerns surrounding his first hospitalization with his social worker and said "it was very therapeutic. I did benefit from it." (S.112) Additionally, Torry participates in various group-therapy sessions provided by the hospital and was "compliant about going to groups." (S.95,96)

Torry was working with the hospital discharge planner, too. Discharge planner Ron Barthelemy had recommended Pilsen Wellness Center for outpatient services as an alternative to ProCare outpatient services. (S.101-102) Mr. Barthelemy had made this recommendation because Torry had spoken with him about concerns he had with ProCare. (S.102) Specifically, Torry was concerned about the age difference in clients served at ProCare because he was young, and much of the ProCare clientele was older. (S.102) Mr. Barthelemy "felt that [Torry] might need a change of scenery in the process of outpatient services" he attends. (S.102) Torry said that he was "100 percent" willing to participate in outpatient services. (S.116) The trial court did not let him explain his willingness to participate in treatment by sustaining the State’s objection to this testimony on the grounds of relevance. (S.116)

Torry's mother had brought him to Westlake on January 1, 2013, because he had been "'manic' per mom." (C.80) His differential diagnosis included "manic" and

"drug abuse." (C.34) The hospital's emergency room doctor, Dr Meeks (S.56) spoke with Dr. Goldberg at the time and noted:

> Spoke [with] Dr. Goldberg -- if p[atien]t doesn't want to take meds won't admit him. Felt that p[atien]t is competent not to take meds.

(C.34)

Torry was admitted, having consented to voluntary admission (A-10). Two weeks later, on January 15, 2013, Dr. Goldberg filed the petition for involuntary psychotropic medication that is the subject of this case. (C.2, original petition; C.25, amended petition) The petition was based in large part on an unsigned letter given to Westlake Hospital by Torry's mother and dated January 3, 2013. (C.31-33) Torry's mother did not testify at the trial. (S.1-128) Torry's counsel noted at the time that the January 3 letter is hearsay, and could only be admitted for information the doctor used in forming his opinion. (S.25-30) The letter purportedly relayed information from Torry's past, the most recent alleged incident occurring "four weeks" before the January 3 letter was written. (S.73; C.31-33) On February 27, 2013, Torry's mother submitted a second written statement indicating that she wanted her son to be discharged to her home without psychotropic medication provided outpatient services were arranged for him and that he was willing to participate in the services. (C.83; S.104-105)

At the conclusion of the involuntary-medication hearing on March 7, 2013, the trial court found that Torry admitted to having a mental illness and

> [i]n his own testimony, he said he'd be willing to take certain medications, but he's got to get on some kind of treatment plan to take the medications, but you want to

> label it as involuntary, but that's just how the order is entered.

(S.125) The trial court authorized the administration of involuntary medication, including, among other psychotropic drugs, Depakote, that had likely given Torry side effects before (S.107-109, Fluphenazine, a drug in the same class as Thorazine that Dr. Goldberg discontinued due to Torry's side effects (S.63), and Invega, "technically" not approved for Torry's diagnosis (S.65). (C.28-29) First the trial court, then this Court, denied motions for stay pending appeal. (S.126; C.85,87)

Torry has never before had an involuntary mental-health order entered against him. (S.110)

ARGUMENT

I. The State failed to prove that Torry met each element of the involuntary-medication statute, Section 2-107.1 of the Mental Health Code.

In finding Torry acknowledged his illness and was willing take medication, the trial court was wrong to force medication on him because Torry had capacity and because taking medication voluntarily is less restrictive than court-ordered medication. The court itself noted that that although the order is considered an "involuntary" one, that "that's just how the order is entered." (S.125) Thus the order warrants reversal. *In re R.K.*, 338 Ill. App. 3d 514, 521-522 (1st Dist. 2003).

It is undisputed that the administration of involuntary mental-health services entails a "'massive curtailment of liberty.'" *In re Barbara H.*, 183 Ill. 2d 482, 496 (1998) *quoting Vitek v Jones*, 445 U.S. 480, 491 (1980). When the State seeks to

forcibly inject an individual with psychotropic medication, the interference with the individual's liberty is particularly severe. *In re Robert S.*, 213 Ill. 2d 30, 46 (2004) *citing Riggins v. Nevada*, 504 U.S. 127, 134 (1992). Our State supreme court expressed two fundamental concerns about psychotropic medications: their significant side effects that can be debilitating, permanent, or even fatal, and their potential for misuse to manage or control recipients rather than for a therapeutic purpose. *In re C.E.*, 161 Ill. 2d 200, 214-216 (1994). Because of these concerns, this Court agreed that mental-health recipients have a constitutionally protected liberty interest to refuse unwanted psychotropic medication. *C.E.*, 161 Ill. 2d at 213-214 (1994) *citing Washington v. Harper*, 494 U.S. 210, 221 (1990).

Our State supreme court upheld 2-107.1's constitutionality, in part, because the section is "narrowly tailored to specifically address the State's concern for the well-being of those who are not able to make a rational choice regarding the administration of psychotropic medications," and because the section's "strict standards" "must be satisfied by clear and convincing evidence *before* medication can be ordered." *C.E.*, 161 Ill. 2d at 218 (italics added); 405 ILCS 5/2-107.1(a-5)(4) (2012). Thus, before a trial court can properly enter an order for forced psychotropic medication, the State must prove each and every one of several elements by clear and convincing evidence; if even one element is not proved by clear and convincing evidence, the petition cannot be granted. 405 ILCS 5/2-107.1(a-5)(4) (2012). "Clear and convincing evidence has been defined as that quantum of proof that leaves no reasonable doubt in the mind of the fact finder about the truth of the proposition in question." *In re C.S.*,

383 Ill. App. 3d 449, 452 (1st Dist. 2008), *quoting In re John R.*, 339 Ill. App. 3d 778, 781 (5th Dist. 2003).

Here, the State failed to prove the following two elements by clear and convincing evidence:

> - that the recipient lacks the capacity to make a reasoned decision about the treatment.
>
> - that other less restrictive services have been explored and found inappropriate.

405 ILCS 5/2-107.1(a-5)(4) (E) and (F) (2012).

A. The evidence weighs in favor of finding that Torry has capacity to make a reasoned decision for himself about psychotropic medication.

A threshold element in involuntary medication cases is the issue of capacity to make a reasoned decision about the treatment. 405 ILCS 5/2-107.1 (a-5)(E) (2012). Capacity is a threshold issue because

> [a] competent person had a right at common law to refuse all types of medical treatment, including life-saving or life-sustaining procedures. This common law right was rooted in the "sacred" right to "personal inviolability." In Illinois, a competent person has a statutory right to refuse all types of medical treatment.

In re Larry B., 394 Ill. App. 3d 470, 476 (5th Dist. 2009), *citing to In re Estate of Longeway*, 133 Ill. 2d 33, 44-45 (1989); 755 ILCS 40/5 (2012). Only when a person lacks capacity can the State, as *parens patriae*, administer involuntary psychotropic medication, "where adequate judicially supervised protection" for a respondent has been obtained. *Id.* But if a person has capacity to make a reasoned decision for himself, a trial court's order for involuntary medication should be reversed. *In re Nicholas L.*, 407 Ill. App. 3d 1061, 1076 (2nd Dist. 2011); *In re Alaka W.*, 379 Ill.

App. 3d 251, 265 (3rd Dist. 2008); *In re Israel*, 278 Ill. App. 3d 74, 39 (2nd Dist. 1996).

The standard of review applied in cases where a respondent alleges lack of clear and convincing evidence of each element necessary for involuntary medication is "against the manifest weight of the evidence." *C.S.*, 383 Ill. App. 3d at 451. "The term 'against the manifest weight of the evidence' means that the opposite conclusion is apparent or that the finding is unreasonable, arbitrary or not grounded on the evidence." *C.S.*, 383 Ill. App. 3d at 451.

Trial courts should consider the following factors to determine whether a mental-health respondent has capacity to make a reasoned decision to take, or refuse, treatment:

> (1) The person's knowledge that he has a choice to make;
>
> (2) The person's ability to understand the available options, their advantages and disadvantages;
>
> (3) Whether the commitment is voluntary or involuntary;
>
> (4) Whether the person has previously received the type of medication or treatment at issue;
>
> (5) If the person has received similar treatment in the past, whether he can describe what happened as a result and how the effects were beneficial or harmful; and
>
> (6) The absence of any interfering pathologic perceptions or beliefs or interfering emotional states which might prevent an understanding of legitimate risks and benefits.

In re Israel, 278 Ill. App. 3d 24, 37 (2nd Dist. 1996). Additionally, "[n]one of these enumerated factors should be considered dispositive, and a court should consider any other relevant factors which it deems might be present." *Israel*, 278 Ill. App. 3d at 37.

These factors reflect the functional elements related to capacity and make clear that the presence of mental illness alone does not render a person incompetent to make certain decisions. *In re Alaka W.*, 379 Ill. App. 3d 251, 265 (3rd Dist. 2008). In fact, "[i]f mental illness were sufficient for the court to find that one is unable to make reasoned decisions regarding treatment, it would be unnecessary in any case for the court to determine whether a respondent can make such decisions." *Alaka W.*, 379 Ill. App. 3d at 265. Thus, even persons who have been adjudicated as mentally ill are nonetheless considered legally competent until proven otherwise. *In re Phyllis P.*, 182 Ill. 2d 400, 401 (1998); 405 ILCS 5/2-101 (2010).

Here, Torry G. understood that he had a choice to make about taking psychotropic medications: according to Dr. Goldberg, Torry had engaged in discussions with the doctor about medications but had ultimately declined them. (S.45) Instead, Torry explained that he would like to find a "reliable medication" to treat his illness. (S.117; S.98) And, importantly, Torry testified that he believed he had symptoms of a mental illness: bipolar disorder. (S.111) Appreciating and acknowledging one's symptoms is a sign of insight and a key to capacity. *Cf. In re Gloria C.*, 401 Ill. App. 3d 271, 283 (2nd Dist. 2010) ("failure to recognize one's mental illness may be evidence that the capacity is lacking"), *citing to In re Gwendolyn N.*, 326 Ill. App. 3d 427, 428 (4th Dist. 2001).

Torry demonstrated an understanding of the proposed medications, testifying that he was not concerned about side effects like weight gain or constipation, but was concerned with the more "deadly" side effects that could occur from psychotropic medication. (S.112) And he had experienced side effects, including, among others, muscle spasms, severe headaches, and orthostatic hypotension. (S.63,106-107)

The hospital had accepted Torry's consent to voluntary admission as a competent decision. 405 ILCS 5/3-400 (2012) (providing a recipient must have capacity for voluntary admission). He had, however, exercised his statutory right to submit a written request for discharge and, in response, the hospital had filed a commitment petition. 405 ILCS 5/3-403 (2012); see A-10 of the appendix to this brief. This Court can take judicial notice of court records from other tribunals. *May Dept. Stores Co. v. Teamsters Union Local No. 743*, 64 Ill. 2d 153, 159 (1976). (The State had likewise asked the court to take judicial notice of commitment documents in its closing argument, S.120) That commitment petition was never acted upon, having been dismissed upon Torry's withdrawal of his written request for discharge. A-16. A later request for discharge again resulted in continued voluntary admission. A-17. This is important to a capacity determination because Torry's consent to voluntary admission was accepted and no involuntary commitment ever occurred. 405 ILCS 5/3-400 (2012); 405 ILCS 5/3-801 (2012); *see also In re Hatsuye T.*, 293 Ill. App. 3d 1046, 1052 (1st Dist. 1997) (where medical professionals treat a patient with mental illness as if he has capacity to make treatment decisions, they are foreclosed from claiming later that he did not). Torry was also willing to take medication and to participate in outpatient treatment. (S.100-102,116,117,125)

Torry had previously received the *type* of treatment at issue, including some of the same psychotropic medications -- and other medications of the same class -- as the medications requested in the involuntary-medication petition. Specifically, Torry testified about his experience with Thorazine, Lithium, Depakote, and Risperdal. (S.106-109)

Torry experienced orthostatic hypotension after receiving Thorazine during his current admission to the extent that Dr. Goldberg discontinued it. (S.63) Dr. Goldberg "forgot" about this (S.63), initially testifying that "I think he responded positive[ly], no serious side effects." (S.49) It was on cross-examination that Dr. Goldberg remembered he had discontinued the Thorazine after Torry's second dosage on February 10, 2013. (S.63) The trial court did not permit questioning about what had happened after the first dosage of Thorazine. (S.116A; see footnote 2 above) Counsel made an offer of proof to indicate what the evidence would have been had counsel been allowed to examine Torry on this point. (S.116A; Torry had asked the doctor to stop the medication based upon the side effect he experienced and the doctor had promised to, but did not.)

Dr. Golberg confirmed that Thorazine is in a category of medications called Phenothiazines. (S.64) One of the requested medications in the involuntary treatment petition, Fluphenazine -- more commonly known by the brand name Prolixin (C.60) -- is also in the category of Phenothiazines. (S.64) Although the written medication information provided to Torry indicates that "[y]ou should not use this medicine if you have had a previous allergic reaction to fluphenazine or to any other phenothiazines, such as *Thorazine*®, Mellaril®, or Stelazine®" (C.60, italics added), Dr. Goldberg

was "not sure what it [the written medication information] says." (S.64) Dr. Goldberg admitted that orthostatic hypotension is also one of the risks of Fluphenazine and "for all the medicines I ordered probably." (S.65)

Orthostatic hypotension is

> a sudden fall in blood pressure that occurs when a person assumes a standing position. It is due to a [neural lesion], which senses a change in blood pressure and adjusts heart rate and activates sympathetic nerve system fibers to cause the blood vessels to narrow and correct blood pressure . . . . Symptoms, which generally occur after sudden standing, include dizziness, lightheadedness, blurred vision, and syncope (temporary loss of consciousness).

http://www.ninds.nih.gov/disorders/orthostatic_hypotension/orthostatic_hypotension.htm

When this condition is caused by medication, "the disorder may be reversed by adjusting the dosage or by discontinuing the medication." *Id.* Notably, one of Torry's emergency-room trips in response to psychotropic medication in the past had been because he "fell over" at his outpatient clinic. (S.106-107)

Torry had also taken Lithium in the past. (S.107) Lithium is one of the medications of the mood-stabilizer class, used to treat bipolar disorder. http://www.nimh.nih.gov/health/publications/mental-health-medications/index.shtml. One possible -- and "serious" side effect of the mood-stabilizer Lithium is headache. http://www.nlm.nih.gov/medlineplus/druginfo/meds/a681039.html. Torry testified that while taking Lithium in the past, he had to go to the emergency room because of severe Lithium headaches. (S.106-107) The headaches he experienced were so severe that he was given morphine and had to have a spinal tap. (S.107)

Although Dr. Goldberg was not requesting to involuntarily administer Lithium to Torry, he was requesting court authority to involuntarily administer other medications of the same type as Lithium -- namely, other medications in the mood-stabilizer class, Carbamazepine (brand name Tegretol), and Depakote/Depakene. (C.40,55; S.36,38) In addition to Lithium, however, Torry had taken Depakote in the past and had experienced side effects from it. (S.108) He could not recall "all of the side effects," but had experienced muscle spasms, restlessness, and "bizarre behavior." (S.108) He explained that he had been under Dr. Goldberg's care at the time and that his behavior "got better" when Dr. Goldberg stopped or discontinued the medication. (S.109) The written medication information on Depakote/Depakene provided to Torry indicates, among other "common" side effects, "tremor," "feeling nervous," and "headache." (C.52)

Torry also testified about taking Risperdal, one of the first medicines he had had to take at age 17, when, he explained, "I did not have the right to decline medicine because I was a minor." (S.109) Torry did not state specific side effects he experienced from Risperdal, having explained that he was on "more than four medications" at the time, but said that he did have side effects and would have stopped taking Risperdal if he could have: "I was experiencing these side effects and I didn't have the right to say no, I don't want to take these medicines." (S.107-109)[4].

[4] Under Illinois law, parents have the right to consent to psychotropic medication for their minor children without a court order, but not electroconvulsive therapy. *See* 405 ILCS 5/2-107.1(a-5) (2012) (petitions for involuntary medication are for *adult* recipients of services only); 405 ILCS 5/2-110.5 (2012) (parent can consent to electroconvulsive therapy for a minor only with court approval).

Although Dr. Goldberg was not requesting to involuntarily administer Risperdal to Torry, he was requesting court authority to involuntarily administer the "parent compound of Risperdal": Invega and Invega Sustenna, an antipsychotic medication used to treat schizophrenia. (S.65; C.4,68) Dr. Goldberg said the "injectable" long-acting version of Invega "will last a month instead of two weeks like Risperdal, but it really is Risperdal." (S.65) Dr. Goldberg confirmed that medication information for Invega provides that you should not take Invega if you have had problems with Risperdal. (S.65-66) Dr. Goldberg testified that Invega is "technically" not approved for treatment of bipolar disorder, but then said "well, I'd have to look at the label." (S.65) The trial court did not then permit Torry's counsel to question the doctor about an earlier statement he had made to counsel, that Invega is not his favorite medication because it is not approved for bipolar disorder. (S.66) Invega, in fact, has not yet been approved for treatment of bipolar disorder by the Food and Drug Administration. *See U.S. Food and Drug Administration (FDA)* approval history for Invega, accessed at the FDA's website, http://www.accessdata.fda.gov/scripts/cder/drugsatfda/index.cfm?fuseaction=Search.Label_ApprovalHistory#apphist.

Overall, Torry was able to prove to the trial court that he had "received similar treatment in the past" and was further able to "describe what happened as a result and how the effects were beneficial or harmful." *Israel*, 278 Ill. App. 3d at 37.

Finally, Dr. Goldberg was not asked whether Torry had interfering pathologic perceptions or beliefs or interfering emotional states which might prevent an understanding of legitimate risks and benefits of the proposed medication. (S.14-84)

The only testimony conceivably pertinent to this *Israel* factor might be Dr. Goldberg's testimony that

> He [Torry] at times thinks [the medication] will poison him and he will be seriously harmed. He's been wanting to kill himself because I was giving him medicine, at least it was reported or indicated some suicidal thinking in young people. I sure don't want him to commit suicide. He accused me of that.

(S.49-50) By contrast, Torry never testified that he thought the medication would "poison" him. (S.106-118) Instead, he explained that he was not worried about what he described as "minor" side effects like weight gain, constipation, or skin problems, but was instead worried about taking medication that could have side effects of suicidal thoughts. (S.112) He explained that he did not wish to have a treatment that came with a risk that "you may hurt yourself on the medicines." (S.112)

The written medication information the hospital staff provided to him for Depakote/Depakene noted that monitoring was needed for, among other concerns, "emergence or worsening of depression, suicidal behavior or ideation, or unusual changes in behavior." (C.53) In fact, the FDA required additional warnings for mood stabilizers in 2008, requiring drug manufacturers "to include new warnings of possible suicide ideation in the prescribing information" for these medications. Psychiatric Times, *FDA Dictates Suicide Ideation Warning for Antiepileptics Used for Bipolar Disorder*, accessed at http://www.psychiatrictimes.com/articles/fda-dictates-suicide-ideation-warning-antiepileptics-used-bipolar-disorder. Included in this list are Depakote and Tegretol -- two of the medications Dr. Goldberg requested here. *Id*. (C.4) Consequently, the National Institute of Health's Medline Plus service contains

the same "precaution" information for both Tegretol (Carbamazepine) (C.40), and Depakote (Valproic Acid) (C.55): that is, "you may become suicidal" or experience negative behavioral changes when taking these drugs. *See National Institute of Health's Medline Plus* drug information for Carbamazepine, http://www.nlm.nih.gov/medlineplus/druginfo/meds/a682237.html, and for Valproic Acid, http://www.nlm.nih.gov/medlineplus/druginfo/meds/a682412.html.

Torry, who had been an "A" student in high school (S.116A), did his homework when asked to consider psychotropic medication. He received the written medication information from both Dr. Goldberg and from a social worker and had discussions with Dr. Goldberg. (S.45-48) Dr. Goldberg said Torry wanted a medication with "no side effects" (S.46), but Torry had testified that he was comfortable with "minor" side effects, just not potentially "deadly" ones. (S.112) Ultimately, he decided against the medication Dr. Goldberg offered, although he had thought it over and was considering Tegretol at one point. (S.46) But at age 21 -- now an adult able to make decisions for himself -- it was his right to consent to or refuse the medication, provided his decision was a reasoned one. *Longeway*, 133 Ill. 2d at 44; *Israel,* 278 Ill. App. 3d at 39. Applying the *Israel* factors, Torry had capacity to make this decision for himself.

The *Israel* case, however, does not stop at its enumerated capacity factors. *Israel* also provides that “[n]one of these enumerated factors should be considered dispositive, and a court should consider any other relevant factors which it deems might be present.” *Israel*, 278 Ill. App. 3d at 37. Here, there was other evidence pointing to Torry's capacity to make his own decision whether to consent to

psychotropic medication or not. Chiefly, there was Dr. Goldberg's statement when Torry initially came to the hospital: the hospital's emergency room doctor, Dr Meeks (S.56), spoke with Dr. Goldberg at the time and noted:

> Spoke [with] Dr. Goldberg -- if p[atien]t doesn't want to take meds won't admit him. Felt that p[atien]t *is competent not to take meds.*

(C.34, italics added) In other words, Dr. Goldberg thought at admission that Torry was competent to refuse medication. (C.34) Torry was admitted to the hospital, however, apparently because he was willing to be there as a voluntary recipient. A-10. Regardless, Dr. Goldberg did not explain why he changed his mind -- if he did -- with respect to Torry's capacity, except to point out that Torry was still not comfortable consenting to medication although Dr. Goldberg told him he believed the risk of developing suicidal thoughts was low. (S.46) Dr. Goldberg thought that Torry's concerns with potential risks of medication "were often illogical or unfounded," although Torry's concerns were substantiated in the written information provided to him as required by the Mental Health Code, 405 ILCS 5/2-102(a-5) (2012), and based on his past experience with the same (Depakote) and similar (Thorazine, Risperdal, Lithium) psychotropic medications.

Here, as in the *Nicholas L.* case, Torry's treating psychiatrist disagreed with his patient's choice to decline medicine. *Nicholas L.*, 407 Ill. App. 3d at 1076. But declining to follow a doctor's treatment recommendation "is not indicative of a lack of capacity to make a reasoned decision." *Id.*, *citing to In re Robert S.*, 213 Ill. 2d 30, 53 (2004). Moreover, the trial court's findings show that it found Torry to have capacity: the trial court found that Torry admitted to having a mental illness and

> [i]n his own testimony, he said he'd be willing to take certain medications, but he's got to get on some kind of treatment plan to take the medications, but you want to label it as involuntary, but that's just how the order is entered.

(S.125) The trial court's statement indicates that, at best, the trial court felt it was *helping* Torry to achieve his goal by entering the order for involuntary medication. But courts cannot be moved to deprive individuals of their liberty based on mental illness alone or in an effort to help those individuals out of concern for their perceived best interests. *See Alaka W.*, 379 Ill. App. 3d at 265 (reversing when trial court found respondent lacked capacity based on mental illness alone where evidence showed she likely had capacity). Likewise, courts should not be tempted, due to the complexity of the evidence, to merely rubber-stamp a psychiatrist's recommendation for psychotropic medications. *In re Robert S.*, 213 Ill. 2d 30, 53 (2004) (noting the trial court's authorization of medication despite the testifying psychiatrist's simplistic assessment that the respondent lacked capacity because he refused to do what the psychiatrist told him to do).

Here, like the respondent in *Israel*, Torry rationally explained the basis for his decision to decline the medications Dr. Goldberg offered. *Israel*, 278 Ill. App. 3d at 39. Where, as here, the evidence weighs greatly in favor of finding that the respondent has capacity pursuant to the *Israel* factors, the trial court's order for involuntary medication should be reversed. *Alaka W.*, 379 Ill. App. 3d at 265.

B. Torry's willingness to accept voluntary medication is less restrictive than the court ordering involuntary medication.

Voluntary treatment is the preferred method for recipients to receive mental-health services in Illinois; this is because a goal of the Code is to provide beneficial treatment with the minimum intrusion. *In re Stephenson*, 67 Ill. 2d 544, 554 (1977). Mental-health treatment that is free from compulsion is more therapeutic and effective than forced treatment. *In re Hays*, 102 Ill 2d. 314, 319-320 (1984). Accordingly, there is a statutory preference for voluntary admission. *Hays*, 102 Ill. 2d at 320; *In re James E.*, 207 Ill. 2d 105, 114 (2003). Indeed, the Code permits a recipient to request voluntary admission even after an involuntary-admission hearing has commenced. 405 ILCS 5/3-801 (2012).

Likewise, the Mental Health Code's involuntary-medication statute does not permit a court to grant authority to force medication on a recipient over his objection if a less restrictive option is available. 405 ILCS 5/2-107.1(a-5)(4)(F) (2012). This Court has held that when other, less restrictive and "less risky" services are available, an order for forced treatment should not be entered. *See In re Austwick*, 275 Ill. App. 3d 769, 777 (1st Dist. 1995) (finding that forced treatment with electroconvulsive therapy was not warranted where less restrictive alternatives were available that posed fewer risks). Thus, before a trial court can properly enter an order for forced psychotropic medication, the court must be satisfied that no less restrictive service is appropriate. 405 ILCS 5/2-107.1(a-5)(4)(F) (2012). This makes sense "[g]iven the fairly invasive nature of psychotropic medications," *In re Suzette D.*, 388 Ill. App. 3d 978, 984 (2nd Dist. 2009), and their known documented use at times "not for the patient's therapy, but for the purposes of managing and disciplining the patient" or for

the sake of care providers' "'convenience.'" *C.E.*, 161 Ill. 2d at 215-216 (citations omitted).

The statutory requirement that no less restrictive alternative to forced treatment is appropriate stems from the broader least-restrictive-alternative doctrine. This doctrine is an issue of a public nature. As commentator and law professor Michael Perlin observed,

> Perhaps no other principle has permeated the full body of mental disability law and litigation as has the doctrine of the least restrictive alternative. … it has been invoked in virtually every major challenge to the limitations of the substantive involuntary commitment power, as well as nearly every significant test case seeking a judicial declaration of a right to treatment, a right to refuse treatment, and a right to after-care and/or de-institutionalization. Moreover, this principle had been incorporated in many civil commitment statutes, and is routinely invoked at individual commitment hearings on a daily basis. The importance of this doctrine to the fabric of the commitment process cannot be overstated.

[citations omitted] Michael L. Perlin, *"Their Promises of Paradise": Will Olmstead v. L.C. Resuscitate the Constitutional "Least Restrictive Alternative" Principle in Mental Disability Law?*, 37 Hous. L. Rev. 999, 1010-1011 (2000).

The Illinois legislature also recognized the public nature of the least-restrictive-alternative doctrine. When revising the Mental Health Code in 1976, the drafters commented about the least-restrictive-alternative requirement: the "growth in the doctrine of the least restrictive [alternative] has been accompanied by a growing realization of the harmful impact of long term hospitalization. [citations omitted] At the same time there has been a growth in community facilities.… Under federal regulations [community mental health] centers must provide short-term inpatient,

outpatient, part-time inpatient, emergency and diagnostic services. By 1969, 350 community mental health centers were participating under the [Community Mental Health Centers] Act." *Report, Governor's Commission for Revision of the Mental Health Code of Illinois*, p. 63 (1976); s*ee People v. Bledsoe*, 268 Ill. App. 3d 869, 872 (1st Dist. 1994) (finding that the report is regularly cited by Illinois courts as a primary source of legislative intent). The legislature amended the Code in 1976 to specifically clarify the trial court's duty to order the least-restrictive alternative. Before its amendment the Code was "confusing because it fail[ed] to confer the specific authority and duty for the court to order such alternative treatment." *Report*, p. 64. The current Code retains the mandate that the court order the least restrictive alternative in commitment proceedings. 405 ILCS 5/3-811 (2012). The least-restrictive alternative in involuntary-treatment proceedings is also mandated, and has been from the statute's beginning. 405 ILCS 5/2-107.1 (1992). The least-restrictive requirement is also one of the reasons our State supreme court upheld the statute's constitutionality. *In re C.E.*, 161 Ill. 2d 200, 219 (1994).

The trial court recognized here that Torry both acknowledged his mental illness and was "willing to take certain medications." (S.125) Given this finding, it is important to interpret the involuntary-medication statute's requirement about less restrictive services to determine whether a recipient's willingess to take medication voluntarily constitutes a "less restrictive service" to forced treatment. 405 ILCS 5/2-107.1(a-5)(4)(F) (2012). Interpretation of a statute is subject to *de novo* review. *In re Mary Ann P.*, 202 Ill. 2d 393, 404 (2002).

In interpreting statutes, courts must give effect to the intention of the legislature. *Mary Ann P.*, 202 Ill. 2d at 405. "The most reliable indicator of the legislature's intent is the language used in the statute, which must be given its plain and ordinary meaning. Where the statutory language is clear and unambiguous, it will be given effect without resort to other aids of construction." *Id*. Based on the plain language of section 2-107.1(a-5)(4)(F), this Court should hold that a competent recipient's willingness to take medication is a "less restrictive service" than forcing medication upon him via a court order for involuntary treatment.

Not only was Torry willing to take medication, he had also worked with the hospital's Discharge Planner on an outpatient program. (S.100-102) The Discharge Planner testified that Torry could attend an outpatient program that was more suited for young-adult clients (Pilsen Wellness Center) than his former outpatient provider where Torry "didn't feel he could get anything out of the program there [because of] the age differences" among the clientele. (S.102) Although Torry's counsel attempted to question the Discharge Planner about an informational flyer from Pilsen Wellness Center, the trial court did not allow the witness to answer the question despite the State having raised no objection. (S.102) Torry explained to the trial court that he was "100 percent" willing to participate in the Pilsen Wellness Center program, but the court did not allow Torry to explain why. (S.116)

Moreover, Torry's mother had notified the hospital and the Discharge Planner in writing on February 27, 2013 (a week before Torry's involuntary-medication trial) that she was willing to have Torry return home provided he agreed to participate in outpatient treatment. (C.83; S.103-105;) Torry's mother had noted in her statement that

she was willing for him to come home although he had not agreed to take medication at the hospital that Dr. Goldberg had proposed. (C.83; S.104-105) Torry's counsel, too, had filed a motion for pretrial conference because Torry had hoped to "resolve this matter without a trial, and ha[d] requested that his treating psychiatrist (Dr. Goldberg) find the most appropriate medication to treat bipolar disorder with the least possible risk of side effects." (C.17-19) Although the motion for hearing was first presented to the trial court on February 20, 2013 (C.17), and again presented before the involuntary-medication trial began on March 7, 2013 (S.10-11), the motion was never ruled upon. (C.1-92; S.1-128)

Willingness to accept services voluntarily should be construed as less restrictive than a court ordering an individual to receive forced treatment. The trial court seemed to understand this, noting that although the order is labeled "involuntary," "that's just how the order is entered." (S.125) Here, with the trial court having recognized Torry's willingness to voluntarily accept treatment, the court erred in granting the order for involuntary administration of medication.

Based on Torry's capacity to make a decision for himself about the medication, and his willingness to accept services voluntarily, the trial court's order for involuntary medication should be reversed.

IV. This appeal falls within recognized exceptions to the mootness doctrine.

The 90-day involuntary medication order appealed here expired on June 5, 2013, so "there is no dispute that the underlying case is moot." *In re Alfred H.H.*, 233 Ill. 2d 345, 350 (2009). Specific appeals of mental health cases, however, "will usually

fall within one of the established exceptions to the mootness doctrine." *Alfred H.H.*, 233 Ill. 2d at 355. The established exceptions are "public interest," "capable of repetition yet avoiding review," and "collateral consequences." *Alfred H.H.*, 233 Ill. 2d at 355-362. Reviewing courts must consider all of these "applicable exceptions in light of the relevant facts and legal claims raised in the appeal." *Alfred H.H.*, 233 Ill. 2d at 364.

Pursuant to *Alfred H.H.*, this Court should decide Torry's appeal on the merits under one of the three established exceptions to mootness; all three exceptions apply here.

Public-interest exception

Objective questions of law rather than subjective questions of "sufficiency of the evidence" can qualify for the public-interest exception to mootness. *Alfred H.H.*, 233 Ill. 2d at 355-357. The public-interest exception to mootness applies when the question presented is of a public nature, there is a need for an authoritative determination for the future guidance of public officials, and there is a likelihood of future recurrence of the question. *Alfred H.H.*, 233 Ill. 2d at 355.

Here, Torry asks this court to determine a question of law: whether *voluntary* acceptance of medication is a less restrictive alternative to court-ordered *involuntary* medication pursuant to the involuntary-medication statute. 405 ILCS 5/2-107.1(a-5)(4)(F) (2012). This is a question of law because it requires this Court to determine the meaning of the "less-restrictive" element of the statute. *See In re Michelle J.*, 209 Ill. 2d 428, 434 (2004) (interpreting the meaning of a particular mental-health statute is a question of law subject to *de novo* review). This question of law is a question of a

public nature because of Illinois's interest in voluntary acceptance as the preferred means of obtaining mental-health treatment. *In re Hays*, 102 Ill. 2d 314, 319-320 (1984). There is a need for an authoritative determination for future guidance on this issue as it is one that has not been decided yet in Illinois. There is a likelihood of future recurrence of the question because individuals who are willing to take medication can nonetheless find themselves facing a petition for involuntary medication. *See e.g., In re Nicholas L.*, 407 Ill. App. 3d 1061, 1067-1068 (2nd Dist. 2011) (respondent petitioned for involuntary medication although consenting to oral, but not injectable long-acting, medication; order reversed on written-information and capacity grounds).

This Court can, therefore, apply the public-interest exception and decide this case on the merits. This Court need look no further as it is only necessary to apply one exception to mootness in order to review an otherwise moot matter.

Reviewing courts, however, sometimes note that more than one exception to mootness applies in a given case. *See, e.g. Val Q.*, 396 Ill. App. 3d at 159-160 (capable-of-repetition exception applied in addition to collateral-consequences exception).

Capable of repetition yet avoiding review

Where a mental health order has expired, but the respondent raises statutory arguments that could recur should he face future proceedings, the "capable of repetition yet avoiding review" exception applies. *Alfred H.H.*, 233 Ill. 2d at 359-360. The "capable of repetition yet avoiding review" exception has two elements: "[f]irst,

the challenged action must be of a duration too short to be fully litigated prior to its cessation. Second, there must be a reasonable expectation that 'the same complaining party would be subjected to the same action again.'" *Alfred H.H.*, 233 Ill. 2d at 358 (citation omitted).

This exception applies to Torry's case. First, the order for psychotropic medication was for a period not to exceed 90 days, a period too short to permit litigation. (C.28) The second element is also met: Torry raises a statutory argument turning on the meaning of the "less restrictive services" element of the involuntary-medication statute. 405 ILCS 5/2-107.1(a-4)(4)(F) (2012). Torry is likely to again face a proceeding for involuntary psychotropic medication, having once been adjudged mentally ill by the trial court, *In re Phyllis P.*, 182 Ill. 2d 400, 402 (1998), and, at age 21, now having a 4-year history of mental illness, *In re Barbara H.*, 183 Ill.2d 482, 492 (1998). Moreover, the statutory questions raised here, if not resolved, could confront him again in the future. *See Alfred H.H.*, 233 Ill. 2d at 360 ("the likelihood of the same statutory provision being [wrongly] 'applied in future cases involving the same party' was sufficient to overcome mootness.") (citation omitted). Thus, the "capable of repetition" exception also applies here.

Collateral-consequences exception

"[T]he collateral[-]consequences exception to the mootness doctrine is applicable in mental health cases and has been recognized by a host of Illinois court opinions, including opinions of this court." *Alfred H.H.*, 233 Ill. 2d at 361-362

(citations omitted). In *Alfred H.H.*, the Illinois Supreme Court recognized "a host of potential legal benefits to such a reversal. For instance, a reversal could provide a basis for a motion *in limine* that would prohibit any mention of the hospitalization during the course of another proceeding." *Alfred H.H.*, 233 Ill. 2d at 362. If a mental health respondent is appealing a first involuntary mental health order, the collateral-consequences exception will be applied. *In re Val Q.*, 396 Ill. App. 3d 155, 159 (2nd Dist. 2009).

Here, Torry testified he had never before had an involuntary mental-health order entered against him. (S.110) Additionally, when Torry had exercised his right as a voluntary patient to submit written requests for discharge, and commitment petitions had been filed, these were both dismissed because Torry had withdrawn his requests and resumed voluntary admission. A-16, A-17. There was also no evidence of *any* matters against Torry in any criminal court. (S.1-128; C.1-92)

A reversal here could provide Torry with the opportunity for a motion *in limine* should he face any future proceeding. *Alfred H.H.*, 233 Ill. 2d at 362. Thus, the collateral-consequences exception also applies here.

CONCLUSION

For the foregoing reasons, Respondent-Appellant Torry G. respectfully requests that this Court reverse the trial court's order for involuntary medication.

Respectfully submitted,
LEGAL ADVOCACY SERVICE

____
One of Torry G.'s attorneys

CERTIFICATE OF COMPLIANCE

I certify that this brief conforms to the requirements of Rules 341(a) and (b). The length of this brief, excluding the Rule 341(d) cover, the rule 341(h)(1) statement of points and authorities, the Rule 341(c) certificate of compliance, the certificate of service, and those matters to be appended to the brief under Rule 342(a) is **29** pages.

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